Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

UNIVERSITY MEDICAL CENTER
PO BOX 5980
LUBBOCK TX 79408

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

Carrier's Austin Representative Box
Box Number 45

MFDR Tracking Number
M4-10-4623-01

MFDR Date Received
JULY 6, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are disputing the denial received by the carrier for past filing. The claim was billed correctly as an Inpatient visit according to the admission order. The carrier denied the claim stating itemized does not match UB04 billing, when in fact the itemized and the UB04 did match. We then sent the claim back for reconsideration and were still denied with the same denial. Upon the second denial we corrected our claim to reflect as an Observation claim, per the carriers request and were denied for past filing as they considered it as a 'new' claim. We feel the carrier should pay the claim since they are the one's that requested us to correct our claim."

Amount in Dispute: $11,268.76

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Upon receipt of this Medical dispute the Office performed a review of the medical billing received from University Medical Center for date of service 1/21/10 for Outpatient Services, the following chronological list of dates received from the health care provider and the outcomes from those reviews. Audit and a denial issued for denial code 17 in which the review found that there were numerous errors on the UB-04 such as Box 13 indicates time admitted was 01 which is 1:00 a.m. Box 16 Discharge hour is stated as being 20 which is 8:00 p.m., the charges on the UB-04 does not completely match the itemized statement with the dates of services and or charges. Box 4 indicates POS is 111 which is inpatient services; the injured worker was not admitted for more than 24 hours. The comment on the explanation of benefits asks the facility to correct their coding on the UB 04 and resubmit… Audit was performed and a denial issued for 29-The time limit for filing has expired. The comment to the provider states 'The Provider has resubmitted this bill as a corrected claim which the following has occurred of removal/added CPT Code/HCPC codes and or change the total charge amount on this bill thus making this a new bill subject to the 95 day timely filing rule. The Office reviewed this requestors billing thoroughly and contracted the facility to discuss this further. The initial three submissions were never corrected and resubmitted to the carrier timely even with the comments added to the explanation of benefits. Upon receiving the corrected the [sic] claims the time limit for filing had expired and the corrected bills that were received on 5/17/10 and 6/7/10 were denied correctly for 29-Time limit for filing has expired as the provider changed the billing as removal/added CPT Code/HCPC codes and or change the total charge amount on this bill…"

Response Submitted by: State Office of Risk Management, PO Box 13777, Austin, TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 20, 2010 – January 21, 2010	Hospital Outpatient Services	$11,268.76	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.
4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated March 15, 2010, April 13, 2010, April 29, 2010, and May 24, 2010
   - 17 – Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate. Please submit corrected billing. Itemized statement does not match UB-04 billing. Bill type reflects 131 which is for out patient services.
   - 193 – Original payment decision being maintained. This claim was process properly the first time.
   - 29 – The time limit for filing has expired.
   - 07 – Payment is included in the allowance for another service/procedure.
   - The provider has resubmitted this bill as a corrected claim which the following has occurred of removal/added CPT/HCPC Codes and/or changed total charge amount on this bill thus making it a new bill and subject to the 95 day timely filing rule.

Issues

1. Did the requestor submit the request for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307?
2. Did the requestor submit the corrected bill in accordance with 28 Texas Administrative Code §102.4(h)?
3. Is the requestor entitled to reimbursement?

Findings

1. In accordance with 28 Texas Administrative Code §133.307(c)(2), the provider shall complete the required sections of the request in the form and manner prescribed by the Division. The provider shall file the request with the MDR Section by any mail service or personal delivery. The request shall include: (A) a copy of all medical bill(s), in a paper billing format using an appropriate DWC approved paper billing format, as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration in accordance with §133.250 of this chapter (relating to Reconsideration for Payment of Medical Bills) Review of the submitted bills shows that the requestor did not submit the bill as originally submitted to the carrier nor did the requestor submit the bills submitted to the carrier relating to reconsideration. The requestor has not met the requirements of 28 Texas Administrative Code §133.307(c)(2).
2. In accordance with 28 Texas Administrative Code §102.4(h), the provider has not submitted documentation to support that the corrected billing was made within the confines of the rule. Review of the original bill, submitted by the respondent, shows the services were billed as an inpatient stay with a billing total of $11,080.16; the corrected bill was received by the respondent on May 17, 2019 and documents that the type of bill was changed to reflect an outpatient visit, numerous HCPCS Codes and CPT Codes were listed and the amount of the bill changed totaling $11,268.76. Therefore, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		March 6, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.